2014 Lake County
Spouse's Employer Statement of Coverage

Lake County Employee Information (Please Print Clearly):

Lake County Employee Name: _____

Lake County Employee Social Security Number: _____

Spouse Name ("Spouse"): _____

Spouse Company Name ("Company"): _____

To Be Filled Out by Spouse's Employer Representative:

I, _____ ("Representative") do hereby acknowledge that the above
Print Company Representative Name

spouse is currently an employee of _____ ("Company").
Print Company Name

Our Company currently (select ONLY one situation):

_____ **A.** does not offer any employer sponsored healthcare plan at this time.

_____ **B.** offers an employer sponsored healthcare plan but the above named Employee does not qualify to participate in plan.

_____ **C.** offers an employer sponsored healthcare plan and the above named Spouse currently **does not** participate in that plan. I understand that the above named Spouse will be eligible to elect coverage as a qualifying event. Plan information is as follows:

[1]Healthcare Insurance Carrier's Name: _____
[1]Date of Open Enrollment: _____

I do hereby attest that the above information is complete and accurate to the best of my knowledge:

	Spouse's Company Representative	Lake County Employee	Employee's Spouse
Signature:	_____	_____	_____
Date:	_____	_____	_____